XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
RYAN YATES
Deputy Attorney General
State Bar No. 279257
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7548
Facsimile: (916) 327-2247
*Attorneys for Complainant*



**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

| | |
|---|---|
| In the Matter of the First Amended Accusation Against:<br><br>**John Courtney Dozier, M.D.**<br>**P.O. Box 1726**<br>**Susanville, CA 96130**<br><br>**Physician's and Surgeon's Certificate No. G 46031,**<br><br>Respondent. | Case No. 800-2017-033164<br><br>**FIRST AMENDED ACCUSATION** |

Complainant alleges:

**PARTIES**

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 16, 1981, the Medical Board issued Physician's and Surgeon's Certificate Number G 46031 to John Courtney Dozier, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2019, unless renewed.

## JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech language pathologist, or audiologist.

5. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are

agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

6. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

7. Section 2241 of the Code states:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

"(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

"(d)(1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

"(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5."

8. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

9. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

**FIRST CAUSE FOR DISCIPLINE**

**(Gross Negligence)**

10. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that respondent committed gross negligence in his care and treatment of patients A, B, C and D[1]. The circumstances are as follows:

Patient A

11. On or about March, 2017, the Medical Board of California (Board) reviewed the prescribing practices of Respondent to deceased patient A. Patient A died of an overdose on June 17, 2012, as a result of Oxycodone intoxication. The Board learned Respondent had prescribed controlled medications, including Oxycodone[2], to Patient A leading up to her death. A Coroner's Report from the Lassen County Sheriff's Office indicated that Patient A's death was due to

[1] The patients in the Accusation will be referred to as patients A, B, C and D. The identification of the patients will be disclosed to the Respondent during discovery.

[2] Oxycodone, brand name OxyContin, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

oxycodone intoxication. Morbid obesity and hypertensive and atherosclerotic cardiovascular disease were other significant conditions.

12. Patient A was a 54-year-old female at the time that she started treating with Respondent. At that initial visit she was diagnosed as having hypertension, hypothyroidism, diabetes mellitus type II, depression, morbid obesity and severe degenerative joint disease of the knees. She was taking multiple medications including Metformin[3], Synthroid[4], Cozaar[5], Atenolol[6], hydrochlorothiazide[7], Halcion[8], Paxil[9], Celebrex[10], alprazolam[11] 1 mg per day and Norco[12] 10 mg 5 per day. Patient A was also on methadone[13] which was not noted on the initial visit of February 16, 2006[14], but later was noted on her second visit of March 22, 2006. At that second visit it was noted that Patient A was on "methadone tapering off".

13. On December 8, 2008, Respondent noted in Patient A's medical record that she had completed a "rehabilitation program for prescription drug addiction." Respondent also noted,

---

[3] Metformin is used to treat high blood sugar levels that are caused by a type of diabetes mellitus or sugar diabetes called type 2 diabetes.

[4] Synthroid (levothyroxine) treats hypothyroidism (low thyroid hormone) and different types of goiters (enlarged thyroid gland).

[5] Cozaar (losartan) is used to treat high blood pressure (hypertension) and to help protect the kidneys from damage due to diabetes

[6] Atenolol, is a medication of the beta blockers type, primarily used to treat high blood pressure and angina.

[7] Hydrochlorothiazide is used to treat fluid retention (edema) that is caused by congestive heart failure, severe liver disease (cirrhosis), kidney disease, or treatment with a steroid or hormone medicine.

[8] Halcion is a fast-acting benzodiazepine commonly prescribed for acute insomnia.

[9] Paxil (paroxetine) is an antidepressant belonging to a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Paroxetine affects chemicals in the brain that may be unbalanced in people with depression, anxiety, or other disorders

[10] Celebrex is a nonsteroidal anti-inflammatory drug used to treat pain or inflammation.

[11] Alprazolam is a benzodiazepine. Alprazolam affects chemicals in the brain that may be unbalanced in people with anxiety. Alprazolam is used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Alprazolam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[12] Norco (acetaminophen and hydrocodone) is used to relieve moderate to severe pain. Norco (hydrocodone) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[13] Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

[14] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

Patient A was seeing a psychiatrist, Dr. B. in Reno and a counselor Dr. R. in Susanville. At that point the Patient A was only taking Tylenol for pain. Respondent did not list substance abuse as a problem in his problem list.

14. On January 12, 2010, Patient A was "worked in early" for "increasing pain with cold, damp weather". Patient A had been using ibuprofen with inadequate pain control. The medical note states "she has had trouble in the past with minor tranquilizers in combination with opiates but she states that her problems were actually more with the minor tranquilizers." The medical note stated Patient A did tolerate Oxycodone reasonably well in the past. The medical note stated Patient A's pain was in the shoulders, low back, hands and the big toes. It also stated, Patient A's "knees are doing relatively well but she has had bilateral knee replacements." Respondent's treatment plan indicated that he would start her back on opiates and "monitor her closely". Respondent reminded Patient A that "since she had only a single kidney that she should avoid nonsteroidal anti-inflammatory drugs as much as possible." Respondent gave her Tramadol 50 mg every 4 hours as needed for pain. Respondent also gave her Oxycodone 5/325 one every 6 hours as needed for pain not controlled by the Tramadol[15]. Respondent indicated he would be checking laboratory studies.

15. On February 17, 2010, Respondent discontinued Patient A's Tramadol and placed her on Oxycodone 5mg, two in the morning and two at night. No laboratory results were documented.

16. On March 19, 2010, no labs were documented and there was no discussion of the opiate treatment in Respondent's medical note.

17. On September 21, 2010, no labs were documented but Respondent performed a back examination. Patient A was started on Alprazolam once again without mention of the prior problems she had with Alprazolam abuse previously noted in 2008 in Respondent's records. The oxycodone was increased to 5 mg 1 or 2 every 6 hours.

[15] Tramadol is a narcotic-like pain reliever. Tramadol is used to treat moderate to severe pain.

18. On February 1, 2011, the patient was seen but there was no back or knee examination. Patient A was given a prescription for 30 day's worth of alprazolam and OxyContin[16]. Respondent also gave Patient A 90 days of the same medications via mail order pharmacy. She was to return for re-evaluation in four months.

19. June 7, 2011, Respondent noted Patient A's pain was "controlled". There was no back examination and no mention of the continuation of the pain medications. Respondent increased Patient A's prescription for Alprazolam due to stress from a number of "family issues" mainly related to her son.

20. On July 7, 2011, Respondent saw Patient A for follow up of spine pain and chronic pain syndrome. Patient A was taking Oxycontin 5 milligrams to be ID. The Alprazolam was decreased to 0.5 mg q6h.

21. On September 15, 2011, Respondent saw Patient A in follow-up for hospitalization for dehydration and acute renal failure. Respondent indicated in his medical note that the review of systems was positive for "back pain and joint pain". The musculoskeletal examination was normal without pain. Patient A's psychiatric examination demonstrated appropriate mood and affect. Respondent made a comment regarding the "history of chronic pain due to multiple musculoskeletal problems". In Respondent's treatment plan he did not mention the chronic pain issues or musculoskeletal condition. For the anxiety state Respondent indicated the patient was slightly worse and that he would "change directions for one month." Respondent encouraged restarting of counseling. Alprazolam and Oxycodone continued to be listed on the medication list.

22. November 9, 2011, Respondent treated Patient A for chronic conditions including chronic pain. Respondent noted Patient A was reported to be functional on present analgesic regimen without adverse effects or non-compliance or diversion. Respondent indicated he would no longer give 30-day bridging prescriptions. Medications were listed multiple times (Alprazolam X3 oxycodone X4). Respondent indicated Patient A was being weaned off of opiates by the psychiatrist. Respondent indicated that Patent A's daughter was managing her regimen.

[16] Oxycodone, brand name OxyContin, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

23. On March 27, 2012, Respondent saw Patient A for follow up of chronic conditions. Respondent noted that Patient A was being weaned off her benzodiazepines and she was being followed by Dr. B. in Reno, and she admitted to overuse of benzodiazepines, which led to a family intervention four weeks before. Respondent also noted that Patient A was being weaned off her oxycodone by her psychiatrist and she admits to overuse of prescription opiates.

24. On June 17, 2012, Patient A died. The coroner's report findings stated that the death of Patient A was due to oxycodone intoxication. Morbid obesity and hypertensive and atherosclerotic cardiovascular disease were other significant conditions.

25. Respondent committed gross negligence in his care and treatment of Patient A, which included, but are not limited to, the following:

(a) Respondent departed from the standard of care by failing to coordinate Patient A's care with the psychiatrist or a pain specialist; and,

(b) Respondent departed from the standard of care by failing to closely monitor Patient A with a known history of substance abuse with Alprazolam and oxycodone; and

(c) Respondent departed from the standard of care by failing to keep organized accurate and legible medical records and his lacking of reference to his own medical records; and

(d) Respondent departed from the standard of care by trusting Patient A with 960 5 mg oxycodone in one month due to her known history of substance abuse; and

(e) Respondent departed from the standard of care by restarting the prescription of Patient A's alprazolam without consulting a psychiatrist or reviewing the prior medical records regarding the prior overuse of alprazolam.

26. On or around September 7, 2017, the MBC received an anonymous complaint against Respondent. The complaint alleged Respondent prescribed controlled medications to patients who were not taking them. It was also alleged that when a patient's urine drug screen showed that the patient had not taken the prescribed medication, Respondent continued to prescribe medications to that patient. CURES reports were obtained on Respondent's prescribing. In Respondent's care and treatment of patients B, C, and D departures from the standard of care were identified as follows:

Patient B

27. Patient B saw Respondent for the first time on April 5, 2012. Patient B was seen for follow up with chronic problems which included tobacco use disorder, long term use of anticoagulants, other aneurysm of unspecified site, peripheral vascular disease, chronic pain syndrome, gastroesophageal reflux and insomnia. Respondent did not perform a complete history and physical. Patient B's assessment for the chronic pain syndrome was from prior right femur fracture with open reduction and internal fixation (ORIF)[17] with intra-medullary rod years ago. Patient B presented at the visit with a chronically draining open wound on the right hip also chronic chest wall pain from prior sternotomy for vascular procedures. Respondent's medical records indicated there was fair control with MS Contin and oxycodone. The specific exact dosages were not listed. Respondent conducted an examination of patient B's chest which showed multiple surgical scars over the anterior chest wall and the midline sternotomy scar. A musculoskeletal examination showed a deep open wound at the lateral aspect of right hip with no significant drainage, surrounding erythema, or induration. Respondent's conclusion was patient B suffered from chronic pain which was multifactorial that left patient B disabled for most physical work. Respondent noted patient B was to continue with the present analgesic regimen and follow up in six weeks. Respondent also prescribed Neurontin[18] and Protonix[19]. Patient B was followed every two to four months with minimal physical examinations of his hips or chest.

28. On March 20, 2013 patient B was on morphine sulfate 400 mg per day and oxycodone 240 mg per day. Patient B was reportedly functional on the analgesic regimen without adverse effects or evidence of non-compliance or diversion.

29. On October 16, 2013, patient B was seen by the Respondent for chronic conditions including peripheral vascular disease, chronic pain syndrome and right hip pain. Patient B indicated that his medications had been stolen when he was assaulted. Although patient B

---

[17] ORIF is the abbreviation for a procedure called open reduction internal fixation which is meant to repair compound bone fractures or severe breaks.

[18] Neurontin is a medication used to help manage certain epileptic seizures and relieve pain for some conditions, such as shingles.

[19] Protonix (pantoprazole sodium) is a proton pump inhibitor (PPI) used to treat gastroesophageal reflux disease and a history of erosive esophagitis.

complained of back pain, Respondent did not conduct a back examination. Respondent's medical record stated that patient B's chronic pain syndrome was worse due to his vascular compromise and the MS Contin was increased to 130 mg four times a day. Patient B was told to stop using methamphetamine. Respondent did not make any changes to the opiates patient B was prescribed.

30. On February 12, 2014, patient B was seen by the Respondent for chronic conditions and for anxiety. Respondent did not perform a physical examination. Patient B still had chronic chest pain and right hip pain. Patient B reported that he had increased anxiety due to the decrease in the pain medication. Respondent prescribed Diazepam for patient B's chest pain and shortness of breath causing anxiety.

31. On October 9, 2014, patient B was seen by the Respondent and was going to slowly taper his oxycodone down to six or seven per day as tolerated. Patient B's morphine intake was to be reduced to 160 mg twice a day. There was no further reduction in patient B's medication until April 17, 2015, when patient B was on 590 morphine milligram equivalents per day. Respondent performed a minimal physical examination. Respondent noted patient B had tenderness in his lower back. Respondent's plan was to decrease patient B's use of opioids by ten percent.

32. On August 7, 2015, patient B was seen by the Respondent with a notation that his medication had been reduced from 560 to 530 morphine milligrams equivalents per day. Respondent did not conduct a back or hip examination. Respondent noted patient B's tapering of medication was to continue.

33. On January 26, 2016, patient B was seen by the Respondent for chronic pain syndrome. Patient B was seen after a long absence and there was no explanation for the long absence noted by Respondent. Patient B's drug screen that day showed the presence of methamphetamine. Patient B stated that his medications had been stolen. Patient B was on 115 mg morphine sulfate extended-release per day plus oxycodone 30 mg 6 per day.

34. On March 31, 2016, patient B was seen by the Respondent for follow-up of chronic pain syndrome with chest pain and right arm pain. Patient B was taking morphine sulfate extended-release 100 mg twice a day and oxycodone 30 mg six times per day. Patient B's urine drug screens in February 2016 showed methamphetamine and also opiates that were not

prescribed by Respondent. Respondent noted that patient B continued to be non-compliant with his prescriptions. Respondent did not change Patient B's prescription.

35. On June 29, 2017, patient B was seen by the Respondent for a chronic pain syndrome. Respondent's physical examination showed that when the patient elevated his arms above the shoulders his hands turned pale and caused more pain after five seconds. Respondent's musculoskeletal examination showed both hands were warm although the right arm radial and ulnar pulses could not be felt. Respondent's back examination showed mild tenderness to palpation over the lower back and upper back. Respondent's assessment was patient B continued to have significant amount of pain for multiple sites including his arms and hips as well as his back, and his arm pain might be vascular in etiology. Patient B's hip and spine pain were felt to be most likely due to multiple traumas over many years. Respondent did not order imaging of patient B's hips. Respondent reviewed a consultation note from a pain management specialist in which a tapering program was recommended. Respondent continued Morphine at 45 mg extended-release twice a day and Oxycodone was to be decreased from 15 mg four times a day to 10 mg 4 times a day. Patient B was to be rechecked again in 3 months. Patient B was to continue diazepam 5 mg twice a day.

36. On July 3, 2017, patient B's urine drug screen again showed a heroin metabolite. The last opiate prescription from Respondent to patient B was prescribed in September of 2017. There was no specific chart note addressing the finding of heroin in the drug screens.

37. Respondent committed gross negligence in his care and treatment of patient B, which included, but are not limited to, the following:

(a) Paragraphs 26 through 35, above, are hereby incorporated by reference as if fully set forth herein; and,

(b) Respondent departed from the standard of care by failing to document prior treatment with opiates, failing to contact the patient's prior physician regarding this patient, and failing to note the red flags in the patient;

(c) Respondent departed from the standard of care by failing to react to the methamphetamine use with a change in the treatment plan at least to include urine drug screens on every visit;

(d) Respondent departed from the standard of care by delaying over two years in obliging the patient to see a pain management specialist; and

(e) Respondent departed from the standard of care by failing to examine the patient's pain generators.

Patient C

38. Patient C was a 56 year-old female who saw Respondent on October 3, 2013, with diagnoses of chronic pain syndrome due to previously established degenerative disc disease and degenerative joint disease of the lumbar spine as well as chronic left knee pain. In Respondent's medical record there was no documentation of a review of the prior imaging studies to support these diagnoses. Respondent did not review patient C's prior treatments for the chronic pain other than opiates. Respondent conducted a physical examination of the lumbar spine and the left knee but no range of motion was recorded for either of those body parts. Patient C also had hepatitis C, hormone replacement therapy, hyperlipidemia, dermatitis and cardiac arrhythmia. Patient C was on high dose opiate therapy approximately 600 MME (morphine milligram equivalents) per day.

39. On July 2, 2014, patient C was seen by the Respondent. In the medical records Respondent indicated that based on patient C's pain questionnaire, patient history, review of systems and physical examination the patient was functional on the present analgesic regimen without adverse effects. Respondent reviewed patient C's CURES report. Respondent indicated that patient C would undergo regular monitoring to evaluate the success of these interventions and to avoid adverse outcomes. Respondent also mentioned that attempts would be made to reduce medication when appropriate. There was no mention of periodic drug screening in patient C's medical record.

40. By August 3, 2014, patient C's medication was at 1870 MME.

41. On May 8, 2017, Respondent initiated a drug screening on patient C.

42. Eventually by February 12, 2018, patient C's medication was decreased to 645 MME.

43. Respondent committed gross negligence in his care and treatment of patient C, which included, but are not limited to, the following:

(a) Paragraphs 38 through 42, above, are hereby incorporated by reference as if fully set forth herein; and,

(a) Respondent departed from the standard of care by failing to consult with an orthopedic specialist or pain management specialist regarding the patient's spinal pain and left knee pain requiring high doses of opiates.

Patient D

44. Patient D initially saw Respondent on October 20, 2013, with a diagnosis of low back pain from a prior failed back surgery. Patient D was a patient with high opiate therapy due to the back pain. Patient D also had significant chronic obstructive pulmonary disease (COPD). Patient D had peripheral artery disease, atherosclerosis cardiovascular disease and a history of radiation exposure. Respondent's plan was to continue high-dose opiate therapy and to recheck in two months to review and discuss his opiate therapy contract at that time. In Respondent's medical records there was no discussion of patient D's COPD and respiratory compromise which could be worsened by high-dose opiate therapy. Patient D's prior treatment with opiates was not clearly specified. In Respondent's medical records there was no discussion of the previous imaging studies performed on patient D. Respondent did not obtain a pulmonary consultation at the onset of patient D's treatment with high dose opiates. Respondent did not obtain a pain management or orthopedic consultation for patient D.

45. By April 1, 2014, patient D was taking 2670 MME per day.

46. By April 24, 2018, patient D was taking 547.5 MME per day.

47. Respondent committed gross negligence in his care and treatment of patient D, which included, but are not limited to, the following:

(a) Paragraphs 44 through 46, above, are hereby incorporated by reference as if fully set forth herein; and,

(b) Respondent departed from the standard of care by failing to initiate opiate reduction in a more timely fashion and also following this patient with high dosages of opiates at four months intervals; and

(c) Respondent departed from the standard of care by failing to obtain a pain management, orthopedic, or pulmonary medicine consultation for the patient.

48. Respondent's conduct, as described above, constitutes gross negligence in the practice of medicine in violation of section 2234(b) of the Code and thereby provides cause to discipline Respondent's license.

**SECOND CAUSE FOR DISCIPLINE**

**(Repeated Acts of Negligence)**

49. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B, C, and D.

Patient A

50 Paragraphs 11 through 25, as more particularly alleged above, are hereby incorporated by reference and realleged as if fully set forth herein.

51. Respondent committed acts of repeated negligence in his care and treatment of patient A, which includes, but are not limited to, the following:

(a) Respondent departed from the standard of care by failing to conduct a complete initial medical history and physical; and

(b) Respondent departed from the standard of care by failing to discuss the risks and benefits of treatment of pain with opiates as demonstrated by the lack of documentation of informed consent; and

(c) Respondent departed from the standard of care by poorly monitoring and record keeping to account for the actual amounts of Alprazolam the patient was taking.

Patient B

52. Paragraphs 27 through 37, as more particularly alleged above, are hereby incorporated by reference and realleged as if fully set forth herein.

53. Respondent committed acts of repeated negligence in his care and treatment of patient B, which included, but are not limited to, the following:

(a) Respondent departed from the standard of care by failing to consider other treatments such as physical therapy or stress reduction to threat this patient's chronic pain.

Patient C

54. Paragraphs 38 through 43, as more particularly alleged above, are hereby incorporated by reference and realleged as if fully set forth herein.

55. Respondent committed acts of repeated negligence in his care and treatment of patient C, which included, but are not limited to, the following:

(a) Respondent departed from the standard of care by failing to document prior treatments and prior imaging studies in the patient;

(b) Respondent departed from the standard of care by failing to perform an adequate physical examination of patient C's lumbar spine and left knee;

(c) Respondent departed from the standard of care by failing to initiate drug screening on the patient until May 8, 2017; and

(d) Respondent departed from the standard of care by failing to document a more complete examination of the patient's back and left knee.

Patient D

56. Paragraphs 44 through 47, as more particularly alleged above, are hereby incorporated by reference and realleged as if fully set forth herein.

57. Respondent committed acts of repeated negligence in his care and treatment of patient D, which included, but are not limited to, the following:

(a) Respondent departed from the standard of care by failing to document the prior treatments and prior imaging studies from the patient.

58. Respondent's conduct, as described above, constitutes repeated acts of negligence in the practice of medicine in violation of section 2234(c) of the Code and thereby provides cause to discipline Respondent's license.

///

## THIRD CAUSE FOR DISCIPLINE

**(Excessive Prescribing)**

59. Respondent is subject to disciplinary action under section 725 of the Code, in that respondent excessively overprescribed in his care and treatment of patients B, C and D as more particularly alleged in paragraphs 28 through 48 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

## FOURTH CAUSE FOR DISCIPLINE

**(Furnishing Drugs to an Addict)**

60. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2241, of the Code, in that respondent prescribed controlled substances and dangerous drugs to patient A, whom he knew or reasonably should have known was using or would be using the controlled substances and dangerous drugs for a nonmedical purpose, as more particularly alleged in paragraphs 11 through 24 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

## FIFTH CAUSE FOR DISCIPLINE

**(Prescribing Controlled Substances Without Prior Appropriate Examination)**

61. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2242, of the Code, in that respondent prescribed controlled substances without an appropriate prior examination and a medical indication in his care and treatment of patient A, as more particularly alleged in paragraphs 11 through 24 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

## SIXTH CAUSE FOR DISCIPLINE

**(Failure to Maintain Complete and Accurate Medical Records)**

62. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that respondent failed to maintain adequate and accurate records regarding his care and treatment of patient A, as more particularly alleged in paragraphs 11 through 24 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

## PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 46031, issued to John Courtney Dozier, M.D.;

2. Revoking, suspending or denying approval of John Courtney Dozier, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering John Courtney Dozier, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: May 16, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*

SA2018302675
13609260.docx